Early Periodic Screening Diagnosis and Treatment
Specialized Services Program
EPSDT Nursing

I. PURPOSE

This document will clarify the process to acquire nursing through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. EPSDT services are available to Medicaid/FAMIS Plus enrollees under 21 years of age. EPSDT nursing may be provided exclusively through EPSDT to eligible persons who have demonstrated a medical need for nursing services according to the Nurse Practice Act. The Nurse Practice Act is defined in Chapter 30 of Title 54.1 of the Code of Virginia.

II. BACKGROUND/DISCUSSION

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the recipient.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its agent as medically necessary.

EPSDT and Community Based Care Waivers

Home and community based waivers are programs designed to serve a specific targeted population. Individuals enrolled in community-based waivers that do not offer nursing or who are currently on a waiting list for community-based waivers may receive EPSDT nursing services. If DMAS or a DMAS contract Managed Care Organization (MCO) receives a request for EPSDT nursing for an individual who participates in a waiver that offers nursing, DMAS will coordinate benefits to ensure that nursing services are authorized through the appropriate DMAS program.

Nursing for Individuals in Managed Care Organizations

DMAS, its' contracted MCOs and their providers, have the responsibility to provide EPSDT services to all Medicaid/FAMIS Plus enrollees under age 21. The full scope of EPSDT treatment is available to all children of Medicaid/FAMIS Plus regardless of their chosen MCO. Therefore, the EPSDT benefit is consistently available to all children enrolled in Medicaid/FAMIS Plus. The EPSDT screenings, treatment, and diagnostic benefits are the same whether they are provided through the enrollee's MCO provider network or through Fee For Services (FFS) provider network.

EPSDT nursing services are included in the services provided by a DMAS-contracted MCO. If an individual who is enrolled with a MCO requires EPSDT nursing services the individual's primary care physician must contact the MCO medical management office to initiate the EPSDT screening process for nursing services.

MCO Addresses and Telephone Numbers can be found on the DMAS website at: http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

III. DEFINITIONS:

Activities of Daily Living (ADL's): Activities usually performed in the course of a normal day in an individual's life; and may include eating, dressing, bathing and personal hygiene, mobility including transfer and positioning, bowel and bladder assistance.

Anticipatory Guidance: A component of an EPSDT screening**.** It includes discussion and counseling to provide the family with information on what to expect in the child's current and next developmental phase. It emphasizes health promotion and preventive strategies. Anticipatory guidance is given in anticipation of health problems or decisions that might occur before the next periodicity visit. Anticipatory guidance topics to be considered for each visit include: health habits, prevention of illness and injury, nutrition, oral health, sexuality, social development, family relationships, parental health, community interactions, self-responsibility and school/vocational achievement. Topics may be discussed in groups or individually. Topics selected must be based on the needs of the individual child. The exact approach, topics selected, priority, and time allotted to any one topic will depend on the child's or adolescent's needs, the provider's professional judgment, and individual circumstances. The American Academy of Pediatrics (AAP) Guidelines for Health Supervision III provides guidelines on topics to cover at each periodic screening visit.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare, Medicaid and State Child Health Insurance programs.

Congregate Private Duty Nursing: Congregate private duty nursing should be provided when more than one Technology (Tech) Assisted Waiver/EPSDT recipient resides in the same home. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two individuals who receive nursing via the Tech Waiver or EPSDT. When three or more waiver/EPSDT nursing patients share a home, service staff ratios are determined by assessing the combined needs of the individuals.

Diagnosis and Treatment Services: Other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The state may determine the medical necessity of the service and subject the service to prior authorization for purposes of utilization review.

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DMAS: The Virginia Department of Medical Assistance Services (DMAS) is the state Medicaid agency that is responsible for administering the EPSDT program.

EPSDT (**Early and Periodic Screening, Diagnosis, and Treatment):** The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

EPSDT Nursing: EPSDT nursing is medically necessary private duty nursing care. EPSDT nursing services consist of medically necessary skilled interventions, assessment, medically necessary monitoring and teaching of those who are or will be involved in nursing care for the individual. EPSDT nursing differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services.

EPSDT Medical Needs Assessment: This form summarizes medical needs and assists to determine the individual's medical necessity for nursing care on a daily basis. The form is completed by the EPSDT screener as documentation of need for EPSDT nursing care.

EPSDT Screener: DMAS enrolled or contracted Medicaid MCO enrolled Physician, Physician's Assistant, or Nurse Practitioner.

EPSDT Screening: EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;
- A comprehensive unclothed physical examination;
- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and health education, including anticipatory guidance.

The chart below indicates when a child should receive an EPSDT screening:

INFANCY	EARLY CHILDHOOD	LATE CHILDHOOD	ADOLESCENCE

1 month	15 months	5 years	12 years
2 months	18 months	6 years	14 years
4 months	2 years	8 years	16 years
6 months	3 years	10 years	18 years
9 months	4 years		20 years
12 months			

FAMIS: FAMIS is Virginia's program that helps families provide health insurance to their children. FAMIS stands for Family Access to Medical Insurance Security Plan. FAMIS is a separate federal program from Medicaid. In Virginia, FAMIS recipients are not eligible for EPSDT treatment benefits when enrolled in a managed care organization.

Fee for Service and Managed Care: DMAS provides Medicaid to individuals through two programs: a program utilizing contracted managed care organizations (MCO) and fee-for-service (FFS), which is the standard Medicaid program. Enrollees in areas without a Managed Care Organization option or those who have insurance from a private carrier receive health benefits that are administered directly from DMAS. This benefit package is called "fee for service" and uses the DMAS provider network to receive healthcare services. "FAMIS fee for service" enrollees are eligible for EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

Home: A place of temporary or permanent residence, not including a hospital, ICF/MR nursing facility, or licensed residential care facility.

Home Health Certification and Plan of Care: Physician certification to verify services are required. Nursing providers may use the CMS 485 or another form that has the same information.

Home Health Nursing: Home health services are services provided by a certified home health agency on a part-time or intermittent basis to a recipient in his/her place of residence. For Medicaid, the recipient does not have to be home bound, but the services must be provided in the recipient's home. Home health services provide skilled intervention with an emphasis on recipient or caregiver teaching.

Inter-periodic Screenings: Screenings that are provided outside of and in addition to the regular periodic screenings in the periodicity schedule above. For example, the Primary Care Provider (PCP) may choose to screen adolescents ages 11-20 in accordance with the AAP schedule rather than biannually as required by the current DMAS periodicity schedule. Any medical provider or a qualified health, developmental or educational professional who comes in contact with the child outside of the formal health care system may request that an inter-periodic screening be performed by the PCP or other screening provider.

MEDALLION: Virginia's primary care case management (PCCM) managed care program administered by DMAS. Recipients in MEDALLION regions are required to select or be assigned to a primary care provider (PCP). The PCP receives a monthly management fee for

their assigned recipients and is responsible for the coordination of all of the recipient's health care needs, including any necessary referrals.

Nurse Practice Act (NPA): Set of laws established by each state or territory to protect the public by regulating who can be a nurse, and what a nurse can do. It includes the education and licensing requirements and provisions for the nurse. It also includes disciplinary procedures and punitive measures for those who violate the NPA. The NPA defines the scope of practice for nurses based on the level and content of their education. The NPA is defined in Chapter 30 of Title 54.1 of the Code of Virginia.

Nursing: The performance of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health and the prevention of illness or disease. Nursing includes the supervision and teaching of those who are or will be involved in nursing care along with supervision and teaching the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board of Nursing. Nursing includes the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

Personal Care Services: Support services provided through EPSDT and home and community-based waivers that are necessary to maintain or improve an individual’s current health status. Personal care services are defined as help with activities of daily living, monitoring of self-administered medications, and the monitoring of health status and physical condition.

Practical Nurse (LPN): "Practical nurse" or "licensed practical nurse" means a person who is licensed or holds a multistate licensure privilege to practice practical nursing.

Practical Nursing: "Practical nursing" or "licensed practical nursing" means the performance of nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board of Nursing.

Prior Authorization (PA): The process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services. Providers and individuals are notified of each PA decision with a system-generated notice. PA for EPSDT nursing services for MEDALLION and FFS enrollees is obtained at DMAS. PA for Managed Care enrollees must be obtained through the MCO.

Private Duty Nursing: See EPSDT Nursing.

Registered Nurse: A registered nurse (R.N.) is a person who is licensed or holds a multi-state licensure privilege to practice professional nursing as defined in the nurse practice act.

Respite: Respite is not an EPSDT service. It is defined as short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

Skilled Nursing: Skilled nursing services provide short-term intermittent skilled interventions with an emphasis on individual and caregiver teaching. Skilled nursing services, such as those available through home health, or the Mental Retardation or Individual and Family Developmental Disabilities Support Waiver, are not offered through EPSDT.

State Plan for Medical Assistance: The set of benefits approved by the Commonwealth of Virginia and the Centers for Medicaid and Medicare Services.

Technology Assisted Waiver (Tech Waiver): This waiver is designed to allow eligible recipients to be cared for in the community rather than an institution. Eligible recipients are individuals who have exhausted available third party benefits for private duty nursing and are dependent on a technology to substitute for a vital body function. All recipients must require substantial and ongoing nursing services.

Third Party Liability (TPL): Insurance other than Medicaid that is owned by the individual or purchased on the individual's behalf. This insurance may be liable for coverage of the requested Medicaid service. TPL must be billed for nursing services prior to billing Medicaid.

Unskilled care: Level of care needed when the condition of the recipient is medically stable and predictable, the needs described in the plan of care do not require the skills of a licensed nurse for medical care monitoring of a specific health condition.

IV. PROVIDER PARTICIPATION REQUIREMENTS

Participating Private Duty Nursing Service Providers

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) nursing is private duty nursing. The Department of Medical Assistance Services (DMAS) reimburses for private duty nursing rendered to individuals authorized for the service through the Technology Assisted Waiver and the EPSDT programs. A participating provider for EPSDT nursing services must be licensed or certified as a home health agency by the Virginia Department of Health (VDH) and must have a current, signed agreement with DMAS to provide private duty nursing services.

PRIVATE DUTY NURSING AGENCIES

Private duty nursing is continuous medically necessary nursing provided for an individual. Private duty nursing agencies provide professional nursing services to individuals in a home or community-based setting. DMAS must preauthorize Medicaid payment for EPSDT nursing for individuals who have been assessed and determined to require nursing in order to safely remain in the home. Nurses employed by the private duty nursing agency will administer medications, treatments, and care (CMS 485 or equivalent) according to a preauthorized plan of care which specifies the amount and type of care to be rendered. EPSDT nursing must be provided by a registered nurse (RN) or licensed practical nurse (LPN) employed by a DMAS/MCO-enrolled private duty nursing provider.

If an agency wishes to participate as a DMAS Private Duty Nursing provider, they should contact Provider Enrollment at:

First Health - Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261-6803

Helpdesk Telephone Numbers:
(804) 270-5105 local
(888) 829-5373 toll free

V. ELIGIBILITY CRITERIA:

To be eligible for EPSDT nursing services the individual must be a currently-enrolled FAMIS Plus recipient under the age of 21 years. Children with third party health insurance are eligible to receive coverage through EPSDT for private duty nursing services. However, the third party insurance must be billed prior to billing Medicaid. **EPSDT nursing is available only to individuals who meet medical necessity criteria for EPSDT nursing services.**

Medical Necessity Criteria for Fee for Service Enrollees

EPSDT nursing provides individualized medically necessary nursing treatment or preventive nursing supports that correct, ameliorate or maintain the health condition. The need for nursing must be documented during either a routine EPSDT screening/well child visit, or during an EPSDT inter-periodic screening for diagnosis or assessment of a specific medical or mental health condition. EPSDT screeners may have nursing staff complete the EPSDT medical needs assessment to document that the individual is eligible to receive EPSDT nursing care. The need for distinct monitoring and evaluative services must be documented in the provider plan of treatment; the need for medical monitoring must be documented in the comments section of the Nursing Needs Assessment. Hospital discharge situations may require the provision of related services such as family training as provided by a nurse. Therefore, during the first 30 days following a hospital discharge a higher level of nursing services is available when documented in the Medical Needs Assessment and the nursing plan of care and approved by DMAS. Nursing may be available for up to 24 hours per day if the individual's medical necessity warrants such intensive nursing care and the care can be safely provided in the home environment. The EPSDT Medical Needs Assessment form and Home Health Certification and Plan of Care are required to document the need for EPSDT nursing.

The EPSDT Medical Needs Assessment form will determine medical necessity for EPSDT nursing. There are five levels of nursing care. Nursing needs of the individual indicate the type and complexity of care. Each nursing need has a score assigned based on the time required to perform the skill. The total score for the nursing needs section must be approved by DMAS and will determine the medical necessity for nursing care. EPSDT nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours approved by DMAS. EPSDT nursing prior authorizations may be valid for the duration of the POC.

A physician, physician's assistant, certified nurse practitioner, or a registered nurse, must complete and sign the EPSDT Medical Needs Assessment form. If the Medical Needs Assessment is completed by a RN, it must be signed by a physician, physician's assistant, or certified nurse practitioner. All EPSDT nursing service requests must have current physician orders for nursing. Individuals who receive EPSDT nursing services must receive a re-assessment by a physician every 6 months. For all Fee for Service enrollees DMAS must receive a copy of the Medical Needs Assessment with each assessment. A decline in the

individual's nursing score generally indicates an improvement in the individual's health condition. Therefore, the number of approved nursing hours will decline as the individual's

health condition improves. Individuals who are denied nursing services must be reassessed when their health condition changes.

The levels of EPSDT nursing care are defined as:

- ❒ **A** Score (1-6) points
  Maximum nursing (Individual Consideration)
- ❒ **B** Score (7-22) points
  Maximum nursing 8 hrs / day
- ❒ **C** Score (23-36) points
  Maximum nursing 12 hrs / day
- ❒ **D** Score (37-49) points
  Maximum nursing 16 hrs / day
- ❒ **E** Score (50 or more) points
  Maximum nursing (Individual Consideration)
  (Usually Tech Waiver Eligible)

VI. SERVICE INITIATION AND REFERRAL PROCESS:

The individual/family or case manager acting on their behalf may request that an EPSDT screener (physician or nurse practitioner) complete the EPSDT Medical Needs Assessment. The screener may bill for an inter-periodic screening for this problem focused visit. The physician, individual or case manager will forward the completed Medical Needs Assessment to DMAS. If the service need is appropriate to receive nursing, DMAS will approve a referral to a DMAS enrolled nursing agency to develop a nursing plan using the Home Health Certification and Plan of Care (CMS-485). DMAS, the individual's caregiver or the individual's case manager will assist the family in choosing a nursing agency in their area (DMAS will refer the individual to a case management agency such as Care Connections or the local Community Services Board at that time if there is no agency to support the individual). The individual will choose a nursing agency in their area. The nursing agency may bill for the assessment visit by using the RN nursing code (S9123). DMAS will review the Medical Needs Assessment form and the POC to assess the level of need and determine if the requested service amount meets EPSDT criteria for reimbursement. The nursing agency must send the Home Health Certification and Plan of Care to DMAS for final approval and pre authorization of EPSDT nursing hours.

Individuals may be eligible to receive services in the Technology Assisted Waiver when they score with the highest level of nursing needs if they meet all of the eligibility criteria to enroll in the Technology Assisted Waiver.

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MCO Service Requests

MCO enrollees must request EPSDT nursing through their respective MCO.

Steps for Requesting Preauthorization:

1. The EPSDT screener will assess for nursing treatment using the EPSDT Medical Needs Assessment.
2. The individual/case manager/family will send the completed Medical Needs Assessment to DMAS.
3. If appropriate, DMAS will authorize a referral for EPSDT nursing and send a nursing provider list to the individual/case manager/family, if necessary.
4. The individual will select an agency and work with their case manager or chosen provider to develop a Home Health Certification and Plan of Care (must use the CMS-485 or equivalent information).
5. The Home Health Certification and Plan of Care will be sent to DMAS.
6. A prior authorization notice will be sent to the provider and the individual to inform them of the DMAS decision to approve, deny, or pend the request for services. If the services are approved, the notification will include the approved hours and time frame for EPSDT nursing. The DMAS approval notice will include a preauthorization number. This number is the provider's authorization to bill for services rendered.

If DMAS requires more information in order to render a decision, the decision is pended. For all pended decisions, the requesting provider receives a request for the needed information from DMAS.

If the service request is denied, a letter will be sent to the provider and individual/family indicating the reason for the denial. This letter will include appeal rights.

Submission of Requests

Requests for services may be faxed to: (804) 786-5799.
Requests for services may be mailed to:

DMAS
Maternal and Child Health Division
600 E. Broad St., Ste 1300
Richmond VA, 23219

Provider Requests must contain the following:

- EPSDT Medical Needs Assessment Form signed by EPSDT screener

- Home Health Certification and Plan of Care (may use the CMS 485 or equivalent to meet documentation requirements) signed by the ordering physician who is most familiar with the care needs of the individual
- The Home Health Certification and Plan of Care must contain the enrollee Medicaid ID number, provider number, and documentation which reflects the nursing care as described in the Medical Needs Assessment (DMAS-62) form

VII. PRIOR AUTHORIZATION REQUIREMENTS

Accurate and complete authorization requests help reduce delays in authorization and service initiation. To ensure timely authorization for services, all requests for service authorization must be submitted to the EPSDT Prior Authorization Coordinator prior to initiation of EPSDT services. Providers will not be reimbursed for services rendered prior to the date of the physician signature. Providers should not start services before receiving an authorization from DMAS. Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided. The provider must have a Medicaid identification number for any authorized individual prior to requesting Medicaid-funded services.

The EPSDT screener must document the need for EPSDT nursing services using the EPSDT Medical Needs Assessment Form and the Home Health Certification and Plan of Care using a CMS 485 or equivalent form. Nursing providers, the family and the physician will collaborate to develop treatment plans that meet the individual's medical nursing needs and that also meet the DMAS definition of EPSDT nursing. During the prior authorization review, DMAS will determine if the individual is involved with waivers and other Medicaid services that may offer an appropriate benefit for the individual. If those existing resources have been attempted, then the provider will document the denial reasons or other reasons for discontinuation or denial of nursing services. Providers need to document the current provision of other medical services, school based services and waiver services that the individual is currently receiving.

If the provider is requesting an extension of services, the request for the extension must be sent to DMAS at least 3 working days prior to the end date of the previous approval to ensure continuous service approval. Extension requests received after the end date of the previous approval may be approved beginning with the date DMAS receives the extension request. For example, if a prior authorization approval ends on 12/1, the provider must submit a request at least 3 days before this date in order to ensure continuation of reimbursement for services. If the request for extension is received on 12/5, the earliest date DMAS can approve the extension request will be 12/5. Therefore, the provider will not be reimbursed for services from 12/2-12/4.

All service requests that are not supported by recent EPSDT screening documentation from a physician will be pended for EPSDT screening documentation of the need for nursing. DMAS will preauthorize Medicaid payment for EPSDT nursing for individuals who have been assessed by their treating physician and determined to require nursing to correct or ameliorate medical conditions which require a skilled medical professional. Nursing services may consist of

medication administration, treatments, and care according to a physician ordered plan of care that specifies the amount and type of care to be rendered. EPSDT nursing must be provided according to the skilled medical needs of the individual, by a registered nurse (RN) or licensed practical nurse (LPN), employed by a DMAS-enrolled nursing provider. The individual cannot be eligible for continued coverage from DMAS Home Health nursing services.

EPSDT nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours approved by DMAS. EPSDT nursing prior authorizations may be valid for the duration of the POC. Plans may be submitted for any time period between 60 days and 6 months as long as the physician, certified nurse practitioner or physician's assitant signs the plan to authorize that the services are medically necessary for the length of time requested. Subsequent requests for services must be prior authorized by DMAS.

The scope and duration of services will be determined on a case-by-case basis by reviewing the nursing plan of care, the EPSDT Medical Needs Assessment and other supporting documentation provided by the physician and/or nursing company.

To inquire about the status of completed prior authorization decisions:

MediCall

You may check the MediCall Automated Voice Response System 24- hours-per-day, seven days a week, to confirm recipient eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the US
1-800-884-9730	Toll-free throughout the US
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification.

Automated Response System (ARS)

Providers may use the Internet to verify recipient eligibility and perform other inquiry functions. You may contact the First Health Services Web Support Call Center at 1-800-241-8726 if you have any questions or problems regarding the ARS Web Site.

VIII. INDIVIDUAL'S RIGHT TO APPEAL AND FAIR HEARING

State [12 VAC (Virginia Administrative Code) § 30-110-70 through 30-110-90] and federal regulations [42 CFR (Code of Federal Regulations) § 431] require a notice of appeal rights to individuals who have had a Medicaid-covered service denied, reduced, suspended, terminated or not acted upon within required time frames.

The individual must be notified in writing of the right to a hearing and the procedure for requesting a hearing at the time of the application and at the time of any adverse action by DMAS or its' contracted MCO, the Case Manager, individual service providers, or the DSS. For

applicants and individuals not familiar with English, a translation of the appeal rights understood by the applicant or individual must be included. Appeal rights at the time of any action by DMAS, the Case Manager, individual service providers, or DSS must be issued at least ten (10) days prior to the date of action, except for specified exceptions. The individual then has (30) days from the date of denial to request an appeal. MCO enrollees may appeal to both the MCO and to DMAS simultaneously.

When an individual's request for a Medicaid-covered service is denied, reduced, suspended, terminated, or not acted upon within required time frames, DMAS, the requesting provider or the requesting case manager must send the written notification of the action and the right to appeal the action to the individual.

The contents of the notification letter must include: (See the "Exhibits" section at the end of this chapter for sample letters.)

1. What action the agency intends to take;
2. The reason(s) for the intended action;
3. An explanation of the individual's right to request a hearing;
4. An explanation of the circumstances under which Medicaid is continued if a hearing is requested;
5. An explanation of the individual's requirement to reimburse DMAS if the agency's action is upheld, if the individual continues to receive a Medicaid-covered service; and
6. The effective date of the action.

IX. COVERED SERVICES AND LIMITATIONS:

EPSDT Nursing (S9123, S9124)

EPSDT nursing must be deemed medically necessary by an attending physician to assess, monitor, and provide medical interventions to treat or maintain the individual's medical condition. The individual must have documented nursing care needs that are required to support and manage a health condition that requires nursing to ensure the health and welfare of the individual. The unit of service for EPSDT nursing is one hour. Payment is available only for allowable activities that are pre-authorized and provided by a qualified provider in accordance with an approved POC and EPSDT program criteria. EPSDT nursing provides both individual and congregate nursing.

Nursing care needs are defined as those services required by the individual that are medically necessary to maintain or improve the physical health of the individual. The service will not be used to specifically monitor medically controlled disorders or to provide unskilled care. EPSDT nursing services are provided on a regularly scheduled basis according to medical necessity. Services such as Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) care are not nursing services and will not be approved as nursing service hours by DMAS unless a concurrent nursing service is being provided to the individual. The total amount of approved nursing hours may include both nursing and personal care time if the personal care tasks are incidental to the nursing care. The need for nursing care defines the amount of nursing services that are approved.

Congregate Nursing (T1030, T 1031)

Congregate private duty nursing must be provided when more than one Tech Waiver/EPSDT individual resides in the same home. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two individuals who receive nursing via a Medicaid waiver or EPSDT. When three or more individuals receiving waiver/EPSDT nursing share a home, service staff ratios are determined by assessing the combined needs of the individuals.

School Nursing

Individuals and caregivers are responsible for determining if the individual is receiving the appropriate nursing benefit in the school system and suggesting that child's Individualized Education Plan (IEP) include nursing coverage in the school system. In cases where nursing is required during school hours, the provider must submit documentation to indicate why nursing is not included in the child's IEP and therefore why the school is not providing nursing coverage.

Home Health Nursing

Home Health Services are services provided by a certified home health agency on a part-time or Intermittent basis to a recipient in his/her place of residence. The individual does not have to be home bound, but the services must be provided in the recipient's home. Home health services

are intended to provide skilled intervention with an emphasis on individual or caregiver teaching. For all maintenance services, the emphasis will be on keeping the individual at home rather than requiring the individual to go to the physician's office, unless physician visits are scheduled and would coincide with the needed home health visits. Home Health Nursing must be accessed through a Home Health Agency that has a provider agreement with DMAS or its contracted MCO to provide Home Health Services. EPSDT nursing will not duplicate the services available through the Home Health program. If nursing services are denied or terminated under home health, then the individual, if under the age of 21, may request nursing under EPSDT.

EPSDT Nursing Non-Covered services:

- Non-medical care or non-medical supervision.
- Respite.

X. DOCUMENTATION REQUIREMENTS:

Services not specifically documented in the recipient's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS.

The medical record must contain sufficient information to clearly identify the recipient, to justify the diagnosis and treatment, and to document the results accurately.

All record documentation must be signed with the employee initials, last name, and title and be dated with complete dates (month, day, year). A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber-stamps initialed by the physician. The physician must initial and completely date all rubber-stamped signatures.

The physician's orders may be documented on the CMS-485 form or an equivalent form which must include the following:

- Individual's Medicaid ID number
- National Provider Identifier (NPI)
- Patient name and address
- Diagnosis and prognosis
- Functional limitations
- Activities permitted
- Mental status
- Safety measures
- Orders for medications/treatments
- Orders for dietary/nutritional needs
- Orders for therapeutic services
- Orders for home health aide services
- Orders for medical tests

- Measurable goals for treatment with established time frames
- Frequency/duration of services
- Rehabilitation potential
- Instructions for discharge or referral

NOTE: When designing nursing plans, please note whether a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a licensed nurse. Nurse delegation practices as defined in the Nurse Practice Act may be used to augment the care for individuals as medically appropriate and available.

Nursing documentation for each individual must be kept at the nursing agency. The individual's nursing record must include the following:

- CMS 485 or other form documenting the nursing plan of care
- EPSDT Medical Needs Assessment Form (DMAS 62)
- Social history: List the family/caregivers that are trained and willing to care for the child with the supplement of nursing services and other health professionals
- Record the family's support system in a schedule format;
- Define any transportation requirements and how they are being met;
- Describe availability of nurse; schedule of daily nursing hours;
- Teaching efforts including delegation, assignment of care and demonstrations from caregivers regarding competency with procedural practices;
- Notes documenting each nursing visit; and
- Equipment and supplies necessary for the individual's care.

Nursing notes must include all of the following:

- First and last name of individual on each page of documentation;
- Date of each visit;
- Time at start and end of service delivery by each nurse;
- Comprehensive patient assessment including medical status, functional status, emotional/mental status, nutritional status, any special nursing procedures, and identification/resolution of acute episodes;
- Treatment and/or caregiver instruction provided; caregiver receptiveness to instruction;
- Outcomes including the individual/family's response to services delivered and response to training;
- Demonstrations of caregiver competencies in nurse-delegated tasks;
- Nursing assessment of the individual's status and any changes in status per each working shift; and
- Full signature and title of nursing provider.

Documentation for re-certification of services by a physician, physician's assistant, or certified nurse practitioner:

- Home Health Certification and Plan of Care (may use the CMS 485 or equivalent to meet documentation requirements) signed by the ordering physician who is most familiar with the care needs of the individual
- The Home Health Certification and Plan of Care must contain the enrollee Medicaid ID number, provider number, and documentation which reflects the nursing care as described in the Medical Needs Assessment (DMAS-62) form
- EPSDT Medical Needs Assessment Form signed by physician, physicians assistant or registered nurse practitioner (required every six months)

XI. CLAIMS AND BILLING

The unit of service for EPSDT nursing is one hour. Payment is available only for allowable activities that are pre-authorized and provided by a qualified provider in accordance with an approved POC and EPSDT program criteria. EPSDT nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours authorized by DMAS.

All EPSDT nursing services are pre authorized by DMAS or its contracted MCO. Payment for EPSDT nursing services requires an existing pre authorization.

Pre authorized EPSDT nursing claims will require a prior authorization number (PA Number) in box 23-c of the CMS 1500 claim form. For procedure codes and descriptions, refer to the attached fee chart.

EPSDT Nursing Reimbursement Table

SERVICE	CODE	LOCATION	RATES
EPSDT RN	S9123	NOVA ROS	31.50/HR 25.94/HR
EPSDT LPN	S9124	NOVA ROS	27.30/HR 22.52/HR
EPSDT Congregate Nursing RN	T1030	NOVA ROS	21.00/HR 18.22/HR
EPSDT Congregate Nursing LPN	T1031	NOVA ROS	18.90/HR 16.52/HR

Early Periodic Screening Diagnosis and Treatment
Specialized Services Program
EPSDT Nursing

EXHIBITS:

EPSDT Nursing Services Forms Description

CMS–485 R 2/94 – Home Health Certification and Plan of Care
DMAS–62 – EPSDT Medical Needs Assessment

EPSDT NURSING SERVICES FORMS DESCRIPTION SHEET

You may download these forms from the DMAS website at www.dmas.virginia.gov.

CMS–485 – Home Health Certification and Plan of Care- This form may be used as the physician's orders and the nursing plan of care simultaneously.

DMAS–62 – EPSDT Medical Needs Assessment Form. This form is completed during an EPSDT screening or health encounter by a Physician or Nurse Practitioner. This form is used by EPSDT screeners to demonstrate preliminary medical necessity for and provide a referral to an EPSDT nursing agency.

Department of Medical Assistance Services
Early Periodic Screening Diagnosis and Treatment (EPSDT)
Medical Needs Assessment (DMAS-62)

Summarize daily medical needs to determine eligibility for EPSDT nursing. A physician, physician's assistant or nurse practitioner must sign the form. If you have questions about this form contact the EPSDT Coordinator at (804) 786-6134.

Please fax the completed referral form to DMAS Maternal and Child Health Division @ 804 786-5799

Patient Name	Medicaid ID #	Patient Address
Patient Phone Number(s)	**Screening Date**	**MD or RNP Signature**

Skilled Nursing Care
(Use a check to indicate care needs)

Nursing needs	Schedule	Points	☑
Suctioning.	> q 1 hr	5	
	Q 1-4 hrs	3	
	Q 4hrs +	2	
Enteral Feeds	continuous	5	
	Q 2 hrs	4	
	Q 3 hrs	3	
	Q 4 hrs or less	2	
Medications (excluding nebulizers) Add 1 pt for dosage mgt	Simple- 1 or 2	3	
	Moderate- 3 to 5	4	
	Complex- 6-9 meds	5	
	Extensive- 10+	7	
Intermittent Catheter	Q 4 hrs	5	
	Q 8 hrs	4	
	Q 12 hrs	3	
	Qd or PRN	2	
Sterile Dressings	Q 8 hrs or less	3	
	> q 8 hrs	2	
Trach Care		5	
IV/ Hyperal	continuous	8	
	8-16 hrs	6	
	4-7 hrs	4	
	< 4 hrs	2	
Assessment and Specialized Treatments	QID	5	
	TID	4	
	BID	3	
	QD	2	
Strict I & O	daily or more	5	
Subtotal Nursing points:			

Tech Need	Schedule	Points	☑
Vent	Dependent	50	
Vent	intermittent	45	
Trach*		43*	
CPAP, BIPAP		25	
Oxygen	continuous	15	
Oxygen	cont./ unstable	35	
Peritoneal	dialysis	45	
J/G-tube	Intermittent	6	
J/G-tube	Intermit./complex	6	
J/G-tube	continuous	15	
J/G Tube	cont. w / reflux	35	
NG tube	continuous	40	
	bolus	25	
IV therapy	continuous	40	
Subtotal Technology Points:			
Total Technology and Nursing points:			

***do not score for trach. if child is vent dependent**

Total Nursing Care Score: _____

❒ **A** Score (1-6) points
Maximum nursing (Individual Consideration)

❒ **B** Score (7-22) points
Maximum nursing 8 hrs / day

❒ **C** Score (23-36) points
Maximum nursing 12 hrs / day

❒ **D** Score (37-49) points
Maximum nursing 16 hrs / day

❒ **E** Score (50 or more) points
Maximum nursing (Individual Consideration)
(Usually Tech Waiver Eligible)

Comments:

Physician's recommendations for nursing care hours at home:

Hours of nursing _____ days per week _____

Final EPSDT nursing care hours and the frequency of care are determined according to the medical necessity as documented in the nursing needs assessment and the nursing plan of treatment

DMAS Approved Nursing Care Score: _____

DMAS Signature/Date: _____

Instructions for completing the EPSDT Medical Needs Assessment (DMAS-62)

1. All individuals are scored upon admission and every 6 months thereafter by a Physician, Physician's Assistant, or Nurse Practitioner. Re-assess individuals upon hospital discharge to determine if care needs have changed. Send all initial assessments and 6-month follow up assessments to DMAS.

2. Individuals must receive a minimum score of 1 point to receive any level of EPSDT nursing services.

3. Scores in the nursing needs section reflect the time needed to perform the skill. The total nursing needs score approved by DMAS determines medical necessity for "substantial and ongoing" nursing care.

4. Ventilator dependent individuals will not receive a technology score for tracheostomy. The need for this technology is included in the score for ventilator.

5. Oxygen must be continuous and needed at least 12 hours per day to receive the score for oxygen use. For intermittent oxygen needs, please describe the use in the "assessment and specialized treatment" section of the form (DMAS will assign points for PRN oxygen use under the assessment category). If an individual has a diagnosis of Bronchopulmonary Dysplasia (BPD) and requires continuous oxygen, 24 hours per day and meets any two of the following conditions, he/she is eligible for the increased points for unstable oxygen:

    - On diuretics
    - Albuterol treatments at least q4hrs around the clock
    - Weight is below 15th percentile for age and gain does not follow normal curve for height
    - >3 hospitalizations in last 6 months for respiratory problems
    - Daily desaturations below doctor ordered parameters and desaturations require nursing intervention
    - Physician ordered restricted fluid intake

6. For an individual to qualify for the intermittent/complex G-tube points, the individual must have documented one of following conditions:

    - swallow study within the last six months that documents reflux
    - treatment for aspiration pneumonia in the past 12 months
    - need for suctioning due to reflux (not oral secretions) at least daily

7. Several areas in the nursing needs section assign points based on the frequency of the need for the activity, e.g. trach suctioning q1hr. The individual's nursing record must support the frequency. The agency plan of treatment and the medical needs assessment must document that the individual needs suctioning at this frequency of on an ongoing basis. Typically, when an individual has an upper respiratory

infection, the need for suctioning increases, the frequency determination should not be based on the individuals needs during illness but on the time when an individual is in their normal health status. Document increased need only when a substantial change in their health status has occurred. An individual does not receive points in the suctioning category if the individual is able to suction his own trach or solely requires oral suctioning.

8. Medication points relate to the complexity of the individual's medication regimen.

   - Individuals who are on one or two routine medications that do not require dosage adjustment based on the individual's condition will receive the "simple medication" points.
   - Individuals who are on more than two medications, one or more of which require close monitoring of dosage, side effects etc. will receive the "moderate medication" points.
   - Individuals who are on more than six medications given on different frequency schedules or who need close monitoring of dosage/side effects of more than four different medications will receive the "complex medication" points.
   - Some individuals receive multiple PRN medications. DMAS must receive documentation (send monthly nursing notes with each plan of treatment) that the individual is actually receiving these meds or these medications to qualify for "complex" points.
   - Nebulizer treatments do not count as medications.
   - When a physician prescribes vitamins and/or mineral supplements and the individual receives all medications solely by G-Tube, these medications are counted in the total number of medications administered.

9. Sterile dressing changes only are eligible for points. Individuals with a trach are ineligible for dressing change points. This is included in the trach care point determination.

10. Special treatments include nebulizer, chest PT etc. that are done on a routine basis. Treatments must require a skilled professional e.g. ROM or splint application are not special treatments. If the treatments are done together, e.g. nebulizer treatments followed by chest PT,TID, the points for TID should be awarded. If the individual has multiple treatments that are given at different schedules that add up to a total of more than four treatments per day, then the QID points can be awarded. For example, an individual gets chest PT BID and specialized ostomy care TID. This individual would be awarded 8 points because of a total frequency of greater than 4 times per day. An individual cannot be awarded more than 8 points in this category no matter how many treatments they receive. Assessment for special treatments is covered in #13.

11. Specialized I/O monitoring is reserved for individuals who need careful monitoring of intake and output. Normally this monitoring would be due to the need for replacement fluids if the output is too large. Types of individuals who would need

this type of monitoring are those with kidney problems, severe dumping syndrome etc. Normal daily measurement of I/O without the need to assess for replacement is not eligible for these points. One way to differentiate whether an individual is eligible for these points is to ask if the nurse does anything with the data. If she does nothing, or just calls the doctor, the individual is ineligible for these points. If she has to make adjustments in tube feeding amounts or rates, the individual is eligible.

12. Individuals require re-assessment (billable as an inter-periodic screening) upon discharge from hospitalization.

13. Assessment and Specialized Treatments- Needs are summarized in the comments section or by an attached letter of medical necessity which describes the condition in need of assessment and regular treatment. The assessment and/or treatments must require a skilled professional e.g. seizure monitoring of a medically controlled seizure disorder are not those which require a skilled professional to provide the assessment or treatments. Indicate the frequency in the table, describe the treatment in the comments section of the form.

14. The Comments section is for major procedures that are not covered elsewhere on the form, e.g. peritoneal dialysis. If you have an individual that you feel has major needs that are not covered, contact the DMAS analyst with information on what the procedure is and the amount of nursing time needed to perform this care. The analyst will review the information and assign a point score for the procedure. Only the DMAS analyst can assign points for procedures in the comments section.

15. The total score for the nursing needs section will determine the medical necessity for nursing care. Individuals who receive EPSDT nursing services must receive a re-assessment by a physician every 6 months. The re-assessment must be included in the chart. If the individual's nursing score declines then that indicates an improvement in the individual's health condition. Therefore, the number of approved nursing hours will decline as the individual's health condition improves.

16. After assigning the points in all the relevant categories, total the points and record at the bottom of the page. DMAS will issue the final score to indicate the level of service needed.

DEFINITIONS

Oxygen, continuous - Individual must require oxygen a minimum of 12 hours out of 24.

Oxygen, unstable, - Dependent on oxygen 24 hours per day plus any 2 of the following:

- Diuretics
- Albuterol treatments at least q4hrs around the clock
- Weight is below 15th percentile for age and gain does not follow normal curve for height
- >3 hospitalizations in last 6 months for respiratory problems
- Daily desaturation below doctor ordered parameters and desaturation requires nursing intervention
- Physician ordered restricted fluid intake

G-tube with reflux - Individual has continuous G-tube feeds plus one of the following swallow study within the last 6 months that demonstrated reflux aspiration pneumonia within the last 12 months need for suctioning due to reflux (not oral secretions) on a daily basis.

Simple medication - One or two medications that do not require dosage adjustment.

Moderate medication - More than two meds that require close monitoring of dosage, side effects etc.

Complex medication - Six or more meds on different frequency schedules. Four or more meds requiring close monitoring of dosage and side effects.

Dressings - Sterile dressings only; Trach dressings are not included in this category.

Special Treatments - Other treatments that are considered skilled e.g. nebulizer. ROM is not a special treatment.

Specialized I/O monitoring - Monitoring that includes judgment of fluid replacement needs.

Assessment - Evaluation of complex medical conditions with daily assessment and treatment need. This area summarizes the daily medically necessary assessments required to determine daily treatment needs for intermittent and variable medical conditions that require the skilled medical interventions provided by a nurse.